2700.4 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Report (Form HCFA-416).--

A. Purpose.--The annual EPSDT report (Form HCFA-416) provides basic information on participation in the Medicaid child health program. Although the Form HCFA-416 was effective April 1, 1990, the quarterly EPSDT Report (Form HCFA-420) which it replaced continued to be submitted for the last two quarters of Federal fiscal year 1990. The information is used to assess the effectiveness of State EPSDT programs in terms of the number of children (by age group and basis of Medicaid eligibility), who:

- o Are provided child health screening services;
- o Are referred for corrective treatment; and
- o Receive dental, hearing, and vision assessments.

The completed report demonstrates the State's attainment of its participant and screening goals. Participant and screening goals are two different standards against which EPSDT participation is measured on the Form HCFA-416.

From the completed reports, trend patterns and projections are developed for the Nation and for individual States or geographic areas, from which decisions and recommendations can be made to ensure that eligible children are given the best possible health care. The information is also used to respond to congressional and public inquiries.

B. Reporting Requirements.--Report annually on the Form HCFA-416 for each Federal fiscal year if you administer or supervise the administration of an approved plan for a federally aided title XIX program. Contact your HCFA RO EPSDT specialist if you need technical assistance in completing this form.

C. Effective Date.--Form HCFA-416 replaced Form HCFA-420, the Quarterly EPSDT Report, effective October 1, 1990.

D. Submittal Procedure.--Submit one copy of Form HCFA-416 to HCFA CO and one copy to the appropriate RO not later than April 1 of the year following the end of the Federal fiscal year being reported. Send the report to:

Health Care Financing Administration
Medicaid Bureau
C4-14-15
7500 Security Blvd.
Baltimore, MD 21244

E. Detailed Instructions.--For each of the following line items, report total counts by age groups and by whether categorically or medically needy. Report age based upon the child's age as of March 31 of the Federal fiscal year of the report.

State.--Enter the name of your State.

Fiscal Year.--Enter the reporting fiscal year.

Line 1--Number of Individuals Eligible for EPSDT.--Enter the total unduplicated number of all individuals under age 21 determined to be eligible for Medicaid, distributed by age and by basis of Medicaid eligibility. Unduplicated means that an eligible person is reported only once, although he or she may have had

more than one period of eligibility during the reporting period. Do not include medically needy individuals under age 21 in this count if you do not cover EPSDT services for the medically needy population. All other Medicaid-eligible individuals under age 21 are considered eligible for EPSDT services, regardless of whether they have been informed about the EPSDT program or whether they accept EPSDT services at the time of informing.

Line 2--Ratio of Recommended Initial or Periodic Screening Services Per Age Group Member.--Make no entries. These fixed values reflect the average number of annual initial or periodic screening services recommended by the American Academy of Pediatrics (AAP) for individuals in each age group. Under this element, proportions are identical for the categorically needy, medically needy, and overall populations for each age group.

NOTE: These expected numbers are based on clustering into four age groups the screening service frequencies recommended by the AAP.

Line 3--Average Period of Eligibility.--Divide the average total months of eligibility during the Federal fiscal year by 12 and enter the quotient. Perform separate calculations for the total column and each age group. The resulting decimal expresses the average proportion of the reporting year that all individuals and those within specific age groups maintained their Medicaid eligibility, regardless of whether eligibility was maintained continuously.

Line 4--Adjusted Ratio of Recommended Initial or Periodic Screening Services Per Age Group Member.--Multiply the ratio of recommended initial or periodic screening services per age group member (see line 2) by the average period of eligibility (see line 3) and enter the product for each age group and eligibility category. Make no entry for the total column. This line item provides the basis for determining what proportion of eligibles in an age group and eligibility category should receive one or more initial or periodic screening services during the reporting year.

Line 5--Proportion of Eligibles Who Should Receive at Least One Initial or Periodic Screening Service.--For each age group and eligibility category, enter the number 1.00 if the corresponding entry on line 4 is equal to or greater than 1.00. Enter the decimal calculated on line 4 if the corresponding entry is less than 1.00. Make no entries for the total column. This line item uses the calculations entered on line 4 to determine the actual proportion of eligibles in an age group and eligibility category who should receive one or more initial or periodic screening services during the reporting year, given the recommended number of annual visits and the average period of eligibility for members of that group.

Line 6--Number of Eligibles Who Should Receive at Least One Initial or Periodic Screening Service.--Multiply the number of individuals eligible for EPSDT (see line 1) by the proportion of eligibles who should receive at least one initial or periodic screening service (see line 5) for each age group and eligibility category. Add the products and enter the result in the total column.

Line 7--Number of Eligibles Receiving at Least One Initial or Periodic Screening Service.--Enter the unduplicated count of individuals, including those enrolled in continuing care arrangements, who received one or more documented initial or periodic screenings during the year. Screening services (see §5122) are comprised of a package of the following minimum set of activities:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);

- o A comprehensive unclothed physical exam;
- o Appropriate immunizations according to age and health history (unless medically contraindicated at the time);
- o Laboratory tests (including appropriate blood lead level assessment); and
- o Health education (including anticipatory guidance).

The sources of data are claims paid for such screening services and other documentation of such services furnished under continuing care arrangements.

NOTE: If you permit screening components to be administered by different providers, you must first verify that all appropriate components have been furnished before reporting a complete initial or periodic screening service. An initial or periodic screening service may be reported as complete if one or more of the required five components were not administered because the screening provider determines them to be medically contraindicated or inappropriate to age and health history. Incomplete screening services which lack medical justification due to failure to administer one or more of the required five components are not be reported. Likewise, interperiodic screenings and vision, dental, or hearing assessments do not constitute the screening services reported here.

Line 8--Participant Ratio.--Enter the percentage that results from dividing the number of eligibles receiving at least one initial or periodic screening service (see line 7) by the number of eligibles who should receive at least one screening service. (See line 6.) Perform separate calculations for the total column and each age group and eligibility category. This ratio indicates the extent to which the number of eligibles who should be screened during the year receive at least one initial or periodic screening service.

Line 9--Expected Number of Initial and Periodic Screening Services.--Multiply the number of individuals eligible for EPSDT (see line 1) by the adjusted ratio of recommended initial or periodic screening services per age group member (see line 4), and enter the product for each age group and eligibility category. Add the products and enter the result in the total column. This line item reflects the number of initial and periodic screening services expected for the number of reported eligibles.

Line 10--Actual Number of Initial and Periodic Screening Services.--Enter the combined number of initial and periodic EPSDT child health screening examinations during the fiscal year. The sources of data include reports from continuing care providers and claims paid for such screening services. Do not enter claims for incomplete or interperiodic screenings, or for vision, dental, or hearing assessments. This number is used to determine the extent to which eligible individuals receive the expected number of screening services.

Line 11--Screening Ratio.--Enter the percentage that results from dividing the actual number of initial and periodic screening services (see line 10) by the expected number of initial and periodic screening services. (See line 9.) Perform separate calculations for the total column and each age group and eligibility category. This ratio indicates the extent to which eligibles receive the number of initial and periodic screening services recommended by the AAP, as adjusted by the proportion of the year they are Medicaid eligible.

Line 12--Number of Eligibles Referred for Corrective Treatment.--Enter the unduplicated count of individuals who, as the result of at least one health problem identified during an initial or periodic screening service, excluding vision, dental, and hearing assessments, were scheduled for another appointment with the screening provider or referred to another provider for further needed diagnostic or treatment service. This element does not include correction of health problems during the course of a screening examination, nor referrals for vision, dental, and hearing services.

Line 13--Number of Eligibles Receiving Vision Assessments.--Enter the unduplicated count of individuals receiving assessments to determine the need for diagnosis and treatment for defects in vision.

Line 14--Number of Eligibles Receiving Dental Assessments.--Enter the unduplicated count of individuals receiving preventive dental services, provided individually or in groups which include:

- o Instruction in self-care oral hygiene procedures;
- o Oral prophylaxis (cleaning of teeth), both necessary as a precursor to the application of dental caries preventives when indicated, or independent of the application of caries preventives for patients 10 years of age or older; and
- o Professional application of dental sealants when appropriate to prevent pit and fissure caries.

Line 15--Number of Eligibles Receiving Hearing Assessments.--Enter the unduplicated count of individuals receiving assessments to determine the need for diagnosis and treatment for defects in hearing.

Line 16--Total Number of Eligibles Enrolled in Continuing Care Arrangements.-Enter the unduplicated count of individuals enrolled in continuing care. (See 42 CFR 441.60.) A continuing care provider is one who:

- o Has a contract or formal agreement with the Medicaid agency to provide screening, diagnosis, and treatment (within the provider's capacity) for conditions identified during the screening, or referral to a provider capable of providing the appropriate services;
- o Maintains the recipient's consolidated health history, including information received from other providers;
- o Assures physicians' services as needed by the recipient for acute, episodic or chronic illnesses or conditions; and
- o Submits reports as required by the State agency to ensure program accountability.

These may include pediatricians, family practitioners and other private practice physicians, health maintenance organizations, prepaid health plans, or community/migrant health centers.

NOTE: The total number of eligibles enrolled in continuing care arrangements is reported for informational purposes only. To the extent that supporting documentation is available, the number of continuing care enrollees who receive initial or periodic screenings is included on line 7, and the number of such services furnished to these individuals is included on line 10.

The format to be used in submitting the Form HCFA-416 is supplied in Exhibit A.

Exhibit B furnishes an example of a completed Form HCFA-416 that achieves the target of 80 percent in both participant and screening ratios. All entries in Exhibit B are either the same fixed values that appear on the actual Form HCFA-416 (i.e., line 2), are fictitious (i.e., lines 1, 3, 7, 10, 12-16), or are derived from combinations of these lines using the formulas given in the instructions (i.e., lines 4-6, 8, 9, and 11). Do not base your submission on the values supplied in this exhibit.

F. Disclosure Statement.--Public reporting burden for this collection of information is estimated to average 19 hours per response, and recordkeeping burden is estimated to average 9 hours per response. This includes time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Health Care Financing Administration, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503. (Paperwork Reduction Project 0938-0354; HCFA # 416)

Exhibit A

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

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Exhibit A (Cont.)

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT (Cont.)

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Exhibit B

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT

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Exhibit B (Cont.)

FORM HCFA-416: ANNUAL EPSDT PARTICIPATION REPORT (Cont.)

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